A bill for an act

relating to human services; amending continuing care provisions, including changes to medical assistance, nursing facilities, and data management; amending Minnesota Statutes 2008, sections 252.282, subdivisions 3, 5; 256B.0657, subdivisions 5, 8; 256B.0913, subdivisions 4, 5a, 12; 256B.0915, subdivision 2; 256B.431, subdivision 10; 256B.433, subdivision 1; 256B.438, subdivision 7; 256B.441, subdivisions 5, 11; 256B.5011, subdivision 2; 256B.5012, subdivisions 6, 7; 256B.5013, subdivisions 1, 6; 626.557, subdivision 12b; repealing Minnesota Statutes 2008, section 256B.5013, subdivisions 2, 3, 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2008, section 252.282, subdivision 3, is amended to read:

Subd. 3. **Recommendations.** (a) Upon completion of the local system needs planning assessment, the host county shall make recommendations by May 15, 2000, and by July 1 every two years thereafter beginning in 2001. If no change is recommended, a copy of the assessment along with corresponding documentation shall be provided to the commissioner by July 1 prior to the contract year.

~~(b) Except as provided in section 252.292, subdivision 4, recommendations regarding closures, relocations, or downsizings that include a rate increase shall be submitted to the statewide advisory committee for review, along with the assessment, plan, and corresponding documentation that supports the payment rate adjustment request.~~

~~(c)~~ (b) Recommendations for closures, relocations, and downsizings that do not include a rate increase and for modification of existing services for which a change in the framework of service delivery is necessary shall be provided to the commissioner by July 1 prior to the contract year or at least 90 days prior to the anticipated change, along with the assessment and corresponding documentation.

Sec. 2. Minnesota Statutes 2008, section 252.282, subdivision 5, is amended to read:

Subd. 5. **Responsibilities of commissioner.** (a) In collaboration with counties and providers, the commissioner shall ensure that services recognize the preferences and needs of persons with developmental disabilities and related conditions through a recurring systemic review and assessment of ICF/MR facilities within the state.

~~(b) The commissioner shall publish a notice in the State Register no less than biannually to announce the opportunity for counties or providers to submit requests for payment rate adjustments associated with plans for downsizing, relocation, and closure of ICF/MR facilities.~~

~~(c) The commissioner shall designate funding parameters to counties and to the statewide advisory committee for the overall implementation of system needs within the fiscal resources allocated by the legislature.~~

~~(d)~~ (b) The commissioner shall contract with ICF/MR providers. Contracts shall be for two-year periods.

Sec. 3. Minnesota Statutes 2008, section 256B.0657, subdivision 5, is amended to read:

Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the self-directed supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistant services identified in the recipient's self-directed supports option assessment;

(2) the plan shall be developed by the recipient or by the guardian of an adult recipient or by a parent or guardian of a minor child, ~~with the assistance of an enrolled medical assistance home care targeted case manager~~ and may be assisted by a provider who meets the requirements established for using a person-centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistant services authorization included in the budget. The amount used each month may vary, but additional funds shall

not be provided above the annual personal care assistant services authorized amount unless a change in condition is documented.

(b) The commissioner shall:

(1) establish the format and criteria for the plan as well as the requirements for providers who assist with plan development;

(2) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

(3) notify the recipient, parent, or guardian of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

(4) provide a copy of the plan to the fiscal support entity selected by the recipient.

Sec. 4. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to read:

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12-month period; or

(2) ~~the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs~~ a budget allocation that is objective and evidence-based utilizing valid, reliable cost data.

Sec. 5. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was

found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 6. Minnesota Statutes 2008, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. The lead agency must ensure that the benefit department recovery system in the Medicaid Management Information System (MMIS) has the necessary information on any other health insurance or third-party insurance policy to which the client may have access. For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to

receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 7. Minnesota Statutes 2008, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective

on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

(b) The fee shall be waived by the commissioner when:

(1) a person is residing in a nursing facility;

(2) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the lead agency with the client's Social Security number at the time of application. The lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid. ~~This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:~~

~~(1) total fees billed to clients;~~

~~(2) total collections of fees billed; and~~

~~(3) balance of fees owed by clients.~~

~~If a lead agency does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the lead agency involved to operate under the procedures set forth in this paragraph.~~

Sec. 8. Minnesota Statutes 2008, section 256B.0915, subdivision 2, is amended to read:

Subd. 2. **Spousal impoverishment policies.** The commissioner shall apply:

~~(1)~~ the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059~~;~~, except that individuals with income at or below the special income standard according to Code of Federal Regulations, title 42, section 435.236, receive the maintenance needs amount in subdivision 1d.

~~(2) the personal needs allowance permitted in section 256B.0575; and~~

~~(3) an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5, and according to the approved federal waiver and medical assistance state plan.~~

Sec. 9. Minnesota Statutes 2008, section 256B.431, subdivision 10, is amended to read:

Subd. 10. **Property rate adjustments and construction projects.** ~~A~~ Nursing ~~facility's~~ facilities completing a construction project that are eligible for a rate adjustment under section 256B.434, subdivision 4f, that were not approved through the moratorium exception process in section 144A.073 must request ~~for~~ from the commissioner a property-related payment rate adjustment ~~and the related supporting documentation of project construction cost information must be submitted to the commissioner~~. If the request is made within 60 days after the construction project's completion date ~~to be considered eligible for a property-related payment rate adjustment~~ the effective date of the rate adjustment is the first of the month following the completion date. If the request is made more than 60 days after the completion date, the rate adjustment is effective on the first of the month following the request. The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the ~~building~~ construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased

projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

Sec. 10. Minnesota Statutes 2008, section 256B.433, subdivision 1, is amended to read:

Subdivision 1. **Setting payment; monitoring use of therapy services.** The commissioner shall ~~promulgate~~ adopt rules pursuant to the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either ~~the nursing facility in the operating cost per diem, to~~ the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475 or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475. Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256B.47, and that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c). For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c), for services not medically necessary. For purposes of this section and section 256B.47, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475~~, and that could be reimbursed separately from the~~

~~nursing facility per diem~~. For purposes of this subdivision, "ancillary services" include transportation defined as a covered service in section 256B.0625, subdivision 17.

Sec. 11. Minnesota Statutes 2008, section 256B.438, subdivision 7, is amended to read:

Subd. 7. **Rate determination upon transition to RUG-III payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using the new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) For the transition to MDS 3.0 and RUGs 4.0, scheduled to take place on October 1, 2009, or subsequent modification to the resident assessment or classification systems, the commissioner shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the RUGs 3.0 operating payment rates in effect on September 30, 2009, or most recent year;

(2) determine the number of resident days assigned to each group for the year ending September 30, 2008, or most recent year;

(3) multiply the amounts in clause (1) by the resident days in clause (2) and compute the sum of the amounts;

(4) adjust the values determined in clause (2) using data provided by CMS, including the crosswalk and other statistical methods determined by the commissioner, to estimate the distribution of the resident days under RUGs 4.0, and determine the estimated total standardized days; and

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the case mix adjusted component of the operating payment rate under the RUGs 4.0 method associated with a RUGs weight of 1.00, and multiply this average rate by the RUGs 4.0 indices published by CMS.

~~(c)~~ (d) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Sec. 12. Minnesota Statutes 2008, section 256B.441, subdivision 5, is amended to read:

Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 11, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Sec. 13. Minnesota Statutes 2008, section 256B.441, subdivision 11, is amended to read:

Subd. 11. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, ~~staff education,~~ direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services

from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics.

Sec. 14. Minnesota Statutes 2008, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

~~(2) the establishment and use of a quality improvement plan. Using criteria and options for performance measures developed by the commissioner, each intermediate care facility must identify a minimum of one performance measure on which to focus its efforts for quality improvement during the contract period;~~

~~(3)~~ (2) appropriate and necessary statistical information required by the commissioner;

~~(4)~~ (3) annual aggregate facility financial information; and

~~(5)~~ (4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review the consolidated standards under chapter 245B and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

Sec. 15. Minnesota Statutes 2008, section 256B.5012, subdivision 6, is amended to read:

Subd. 6. **ICF/MR rate increases October 1, 2005, and October 1, 2006.** (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements~~,~~ or receivership agreements~~, or Minnesota Rules, part 9553.0075,~~ is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 16. Minnesota Statutes 2008, section 256B.5012, subdivision 7, is amended to read:

Subd. 7. **ICF/MR rate increases effective October 1, 2007, and October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008. For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12. A facility whose payment rates are governed by closure agreements~~,~~ or receivership agreements~~, or Minnesota Rules, part 9553.0075,~~ is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy-five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and

(3) persons paid by the facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal

hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Sec. 17. Minnesota Statutes 2008, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after October 1, 2000, when there is a documented increase in the needs of a current ICF/MR recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1). Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming which is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; or

(4) a demonstrated behavioral need that significantly impacts the type or amount of services needed by the individual.

(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.

(d) The facility shall provide ~~a quarterly~~ an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.

(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.

Sec. 18. Minnesota Statutes 2008, section 256B.5013, subdivision 6, is amended to read:

Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

(1) make a determination to approve, deny, or modify a request for a variable rate adjustment within 30 days of the receipt of the completed application;

(2) notify the ICF/MR facility and county case manager of the duration and conditions of variable rate adjustment approvals; and

(3) modify MMIS II service agreements to reimburse ICF/MR facilities for approved variable rates~~;~~ .

~~(4) provide notification of legislatively appropriated funding for facility closures, downsizings, and relocations;~~

~~(5) assess the fiscal impacts of the proposals for closures, downsizings, and relocations forwarded for consideration through the state advisory committee; and~~

~~(6) review the payment rate process on a biannual basis and make recommendations to the legislature for necessary adjustments to the review and approval process.~~

Sec. 19. Minnesota Statutes 2008, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall ~~destroy data~~ maintain data for at least a period of three calendar years after date of receipt.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not

required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead agency; and

(ix) when a lead agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the

district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be ~~destroyed~~ maintained under the following schedule:

(1) data from reports determined to be false, ~~two~~ maintained at least a period of three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained at least a period of four years after the finding was made;

(3) data from reports determined to be substantiated, maintained at least a period of seven years after the finding was made; and

(4) data from reports which were not investigated by a lead agency and for which there is no final disposition, ~~two~~ maintained at least a period of three years from the date of the report.

(e) The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:

(1) whether and where backlogs of cases result in a failure to conform with statutory time frames;

(2) where adequate coverage requires additional appropriations and staffing; and

(3) any other trends that affect the safety of vulnerable adults.

(f) Each lead agency must have a record retention policy.

(g) Lead agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Upon completion of the review, not public data received by the review panel must be returned to the lead agency.

(h) Each lead agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead agency may notify other affected parties and their authorized representative if the agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 20. **REPEALER.**

Minnesota Statutes 2008, section 256B.5013, subdivisions 2, 3, and 5, are repealed.

256B.5013 PAYMENT RATE ADJUSTMENTS.

Subd. 2. **Other payment rate adjustments.** Facility total payment rates may be adjusted by the commissioner following the recommendation of both the host county and the statewide advisory committee if, through the local system needs planning process, it is determined that a need exists to amend the package of purchased services with a resulting increase or decrease in costs. Except as provided in section 252.292, subdivision 4, if a provider demonstrates that the loss of revenues caused by the downsizing or closure of a facility cannot be absorbed by the facility based on current operations, the host county or the provider may submit a request to the statewide advisory committee for a facility base rate adjustment. Funds for this purpose are limited to those made available through a legislative appropriation and published in the State Register notice required by section 252.282, subdivision 5.

Subd. 3. **Relocation.** (a) Property rates for all facilities relocated after December 31, 1997, and up to and including October 1, 2000, shall have the full annual costs of relocation included in their October 1, 2000, property rate. The property rate for the relocated home is subject to the costs that were allowable under Minnesota Rules, chapter 9553, and the investment per bed limitation for newly constructed or newly established class B facilities.

(b) In ensuing years, all relocated homes shall be subject to the investment per bed limit for newly constructed or newly established class B facilities under section 256B.501, subdivision 11. The limits shall be adjusted on January 1 of each year by the percentage increase in the construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics in October of the previous two years. Facilities that are relocated within the investment per bed limit may be approved by the statewide advisory committee. Costs for relocation of a facility that exceed the investment per bed limit must be absorbed by the facility.

(c) The payment rate shall take effect when the new facility is licensed and certified by the commissioner of health. Rates for facilities that are relocated after December 31, 1997, through October 1, 2000, shall be adjusted to reflect the full inclusion of the relocation costs, subject to the investment per bed limit in paragraph (b). The investment per bed limit calculated rate for the year in which the facility was relocated shall be the investment per bed limit used.

Subd. 5. **Required occupancy data.** Facilities shall maintain monthly occupancy bed use data by client and report this data monthly in a format determined by the commissioner.